MARICOPA INTEGRATED HEALTH SYSTEM

Count on us to care.

MARICOPA INTEGRATED HEALTH SYSTEM
APPLICATION FOR CLINICAL CLERKSHIP

1. Personal Data:

a. Name_____ b. Social Security Number _____

c. Current Address _____

Current Phone (____)_____ Email_____

d. Emergency Name _____

Emergency Address_____

Emergency Phone (____)_____ Pager (____)_____

MUST BE COMPLETED

2. Education

a. Undergraduate _____

City/State _____

b. Medical _____

City/State _____

c. Expected date of Medical School Graduation _____

d. If foreign medical student,

1. USMLE Scores #1 #2 #3

2. Clinical Skills Exam Passed _____Yes _____No _____Scheduled

CLERKSHIP

a. Have you previously completed any clerkship/electives at Maricopa Medical Center?
(Indicate rotation and inclusive dates.) YES_____ NO_____

Rotation #1_____Dates _____ ( ) 3rd year ( ) 4th year

Rotation #2 _____ Dates _____ ( ) 3rd year ( ) 4th year

Rotation #3 _____ Dates _____ ( ) 3rd year ( ) 4th year

Rotation #4 _____ Dates _____ ( ) 3rd year ( ) 4th year

b. Current Rotation Request:

Rotation Title Dates (Inclusive)

_____

_____

c. If requesting a senior rotation, have you previously completed a junior (core) Clerkship in that specialty? YES_____ NO_____

d. Have you ever been charged with a violation of any statute of any state, the U.S. of any foreign country?

If yes, explain _____

3. Please circle your specialties of interest:

Anesthesiology	OB/GYN
Emergency Medicine	Ortho
Family Medicine	Pediatric
Internal Medicine	Psychiatry
Medicine/Pediatrics	Surgery

4. Procedure for filling application:

Return completed application and required materials (see enclosed policy) to:

Maricopa Integrated Health System
Department of _____
2601 E. Roosevelt
Phoenix, AZ 85008

_____ _____
Applicant's Signature Date

OFFICE USE ONLY

Department: _____

Department Approved Dates: _____

Department Approval: _____
Program Director Signature

GMEC Approval Date _____